AMENDED IN SENATE APRIL 21, 2003

AMENDED IN SENATE APRIL 7, 2003

SENATE BILL No. 26

Introduced by Senator Figueroa
(Principal coauthor: Senator Burton)
(Principal coauthor: Assembly Member Laird)

December 2, 2002

~~An act to amend the heading of Article 1.5 (commencing with Section 510) of Chapter 1 of Division 2 of, and to add Section 513 to, the Business and Professions Code,~~ *An act* to add Article 6.5 (commencing with Section 1385.1) to Chapter 2.2 of Division 2 of the Health and Safety Code, and to add Article 4.5 (commencing with Section 10181) to Chapter 1 of Part 2 of Division 2 of the Insurance Code, relating to health care, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

SB 26, as amended, Figueroa. Health care providers health care rate approval.

(1) ~~Existing law does not regulate the reporting by a health care provider to a consumer credit reporting agency of nonpayment or late payment for health care services provided by the provider to a health care consumer.~~

~~This bill would prohibit a health care provider from reporting a health care consumer as delinquent to a consumer credit reporting agency relative to any delay in payment by a payor for covered health care services provided by the provider to the health care consumer for which the provider reasonably expects payment from the payor.~~

~~(2)~~ Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Under existing law, no change in premium rates or coverage in a group health care service plan or group health insurance may become effective without prior written notification of the change to the group contractholder. Existing law prohibits a plan and insurer during the term of a contract from changing the rate of the premium, copayment, coinsurance, or deductible during specified time periods.

This bill would require approval by the Department of Managed Health Care or the Department of Insurance of an increase in the amount of the premium, copayment, coinsurance obligation, deductible, and other charges under a health care service plan or health insurance policy. The bill would require refunds by a plan or insurer of any increases in these rates imposed between April 1, 2000, and January 1, 2004, to the extent they fail to satisfy specified criteria.

The bill would authorize the Department of Managed Health Care and the Department of Insurance to charge a health care service plan and a health insurer, respectively, a fee for the cost of implementing these rate approval provisions. The bill would require the fees be deposited into rate approval funds that would be created in the State Treasury and continuously appropriated to implement the rate approval process.

Because the bill would specify penalties, including criminal penalties, for the violation of its provisions, the bill would impose a state-mandated local program.

~~(3)~~

(2) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: yes. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

~~SECTION 1. The heading of Article 1.5 (commencing with Section 510) of Chapter 1 of Division 2 of the Business and Professions Code is amended to read:~~

~~Article 1.5. Miscellaneous~~

~~SEC. 2. Section 513 is added to the Business and Professions Code, to read:~~

~~513. (a) A provider shall not report a health care consumer as delinquent to a consumer credit reporting agency relative to any delay in payment by a payor for covered health care services provided by the provider to the health care consumer for which the provider reasonably expects payment from the payor.~~

~~(b) As used in this section, the following terms shall have the following meanings:~~

~~(1) "Consumer credit reporting agency" shall have the same meaning as defined in subdivision (d) of Section 1785.3 of the Civil Code.~~

~~(2) "Payor" shall mean a health care service plan or a health insurer.~~

~~(3) "Provider" shall have the meaning as defined in paragraph (5) of subdivision (d) of Section 511.1.~~

~~SEC. 3.~~

SECTION 1. The Legislature finds and declares the following:

(a) Managed care strategies in the private marketplace have failed to control the amount of the premiums charged for private health care coverage. As a result, premiums for private health care coverage are soaring.

(b) Small employers and individual consumers who have little bargaining power bear the burden of those premium increases. California employers with 50 or fewer employees experienced a premium increase of approximately 20 percent in 2002, 19.99 percent in 2001, and 17.12 percent in 2000. Experts predict that this trend will continue indefinitely. According to the State Trade and Commerce Agency, small businesses comprise nearly 98 percent, or 2.5 million, of all businesses in this state, employ more

than 50 percent, or 7.5 million, of California's workforce, and generate more than one-half of the state's gross domestic product.

(c) During this same period of soaring private health care coverage premiums, California private health care service plans have enjoyed record profits. This demonstrates that these soaring premiums are disproportionate to, and not required to pay, the allegedly increasing hospital, pharmaceutical, or health care provider costs.

(d) During this same period of soaring private health care coverage premiums, private health care service plans have also amassed unprecedented surpluses, far beyond surpluses traditionally required to support the benefits they provide. This, as well, demonstrates that these soaring premiums are disproportionate to, and not required to pay, the allegedly increasing hospital, pharmaceutical, or health care provider costs.

(e) Employers that have chosen to value their employees and their families by providing them health care benefits are increasingly burdened by the skyrocketing cost of private health care coverage premiums. These employers may already be at a competitive disadvantage to companies that do not provide health care benefits to their employees.

(f) Skyrocketing health care coverage premiums, copayments, coinsurance, and deductibles forced many employers to drop coverage altogether, reduce benefits, or purchase plans with high deductibles, copayments, or coinsurance obligations. In fact, a February 2003 Kaiser Family Foundation Health Research and Educational Trust study revealed that in 2002, more employers reduced health care benefits than increased those benefits. Moreover, 61 percent of those employers with 200 or more employees reported that they have increased the amount their employees are required to pay for health care benefits, 55 percent of those employers reported they have increased the amount their employees are required to pay for prescription drugs, and approximately 33 percent of those employers reported they have increased the amount their employees are required to pay in deductibles and for physician office visits.

(g) When employers drop or reduce coverage or pass on large costs to employees, the number of uninsured and underinsured Californians who must seek care at the state's expense increases.

(h) The great majority of the 6.5 million Californians without health care coverage are members of working families who are without this coverage largely due to the fact that private health care coverage premiums are too expensive. This trend will only increase as private health care coverage premiums continue to skyrocket indefinitely during a period of slow economic growth.

(i) For California businesses to remain competitive and to safeguard California's fiscal solvency, the cost of private health care coverage premiums must be brought under control.

(j) Prior to 1988, the marketplace for automobile insurance was in a similar state. For the last 15 years, since the adoption of Proposition 103, automobile insurance companies in California have been required to justify proposed premium increases and seek approval from a state agency before imposing those rates.

(k) During the decade following institution of the approval process for premium increases, the average automobile insurance premium per policyholder decreased four percent while those insurance products remain broadly available and competitive, and the uninsured motorist population declined 38 percent. Nationally, rates increased 25 percent during the same time period. California has experienced the lowest rate change of any state in the nation since the adoption of Proposition 103.

~~SEC. 4.~~

SEC. 2. Article 6.5 (commencing with Section 1385.1) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

Article 6.5. Approval of Rates

1385.1. (a) The following definitions apply for the purposes of this article:

(1) ''Applicant'' means a health care service plan seeking to increase the rate it charges its subscribers.

(2) ''Rate'' includes, but is not limited to, premiums, copayments, coinsurance obligations, deductibles, charges, and the cost of coverage per exposure base unit.

(b) Definitions for the terms used in subdivision (a) of Section 1385.4 may include, but shall not be limited to, whether approving the application will result in a rate that is in accordance with generally accepted actuarial principles.

1385.2. (a) No applicant shall increase the rate it charges a subscriber unless it submits an application to the department, and the application is approved by the department.

(b) Every application submitted to the department pursuant to this section shall be signed by the officers of the applicant who exercise the functions of a chief executive and chief financial officer. Each officer shall certify under penalty of perjury that the representations, data, and information provided to the department to support the application are true.

(c) Every application submitted to the department pursuant to this section shall include, in summary form, the following information:

(1) The rate of return that will result if the application is approved.

(2) The average premium increase per affected subscriber that will result from approval of the application.

(3) The medical loss ratio reserves and surpluses that will result if the application is approved.

(4) A summary of all of the applicant's nonmedical expenses for the most recent fiscal year.

(d) All materials submitted to support an application shall be a public record. The summaries required by the applicant shall be posted on the department's Internet Web site within 10 days of the date of their receipt by the department.

1385.3. A rate increase imposed by a health care service plan between April 1, 2000, and January 1, 2004, shall be a rate application for purposes of this article. If it fails to comply with the requirements of subdivision (a) of Section 1385.4, the department shall order a refund in an amount required to ensure compliance with those requirements, together with interest at the prevailing rate from the date the rate increase was imposed.

1385.4. (a) No application, pursuant to Section 1385.2 or 1385.3, shall be approved if its rate is excessive, inadequate, or unfairly discriminatory or if the plan's benefits are unreasonable in comparison to the rate, or the application otherwise violates this article.

(b) The applicant has the burden to provide the department with evidence and documents establishing the application's compliance with the requirements of subdivision (a).

1385.5. The department shall conduct its review of an application pursuant to subdivision (a) of Section 1385.4 in accordance with regulations determining reasonable rates of return, reserves, surplus, and nonmedical expense amounts.

1385.6. (a) If the department disapproves the application submitted under Section 1385.2 or orders a refund pursuant to Section 1385.3, the applicant may petition for a hearing pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(b) The applicant has the burden at the hearing of proving by a preponderance of the evidence that the application or the rate charged by the health care service plan between April 1, 2000, and January 1, 2004, meets the requirements of subdivision (a) of Section 1385.4 or the failure to approve the application or requiring the payment of a refund pursuant to Section 1385.3 will result in an unconstitutional confiscation. If the applicant prevails in this proof, the department shall order the minimum nonconfiscatory rate or refund.

(c) At least 30 days before the date of a hearing held under this section, the department shall notify the public of the hearing and the procedures for intervening in the hearing pursuant to Section 1385.8 by posting this information on its Internet Web site.

(d) Nothing in this section limits the discretion or authority of the department to provide interim or temporary relief from a potentially confiscatory rate or from a confiscatory rate.

1385.7. A consumer or an intervenor participating pursuant to Section 1385.8 may request that the director hold a hearing to determine whether an existing rate charged by a health care service plan satisfies the requirements of subdivision (a) of Section 1385.4. If the request is denied, the director shall provide a written explanation of his or her reasons for the denial.

1385.8. A consumer or a group representing the interests of consumers may petition to intervene in a proceeding under this article and to obtain compensation pursuant to the provisions of Section 1348.9 and the regulations adopted to implement that section.

1385.9. A violation of this article is subject to the penalties set forth in Section 1859.1 of the Insurance Code. The director may also suspend or revoke the license of a health care service plan for a violation of this article.

1385.10. (a) The department may charge health care service plans a fee for the actual, reasonable costs of implementing this article.

(b) The fees shall be deposited into the Health Care Service Plan Rate Approval Fund which is hereby created in the State Treasury. Notwithstanding Section 13340 of the Government Code, all moneys in this fund are continuously appropriated to the department for the sole purpose of implementing this article.

1385.11. The department has all necessary and proper powers to implement this article including, but not limited to, the authority to adopt regulations. The department shall adopt regulations to implement this article not later than July 1, 2004.

~~SEC. 5.~~

SEC. 3. Article 4.5 (commencing with Section 10181) is added to Chapter 1 of Part 2 of Division 2 of the Insurance Code, to read:

Article 4.5. Approval of Rates

10181. (a) The following definitions apply for the purposes of this article:

(1) ''Applicant'' means a health insurer seeking to increase the rate it charges its policyholders.

(2) ''Rate'' includes, but is not limited to, premiums, copayments, coinsurance obligations, deductibles, charges, and the cost of insurance per exposure base unit.

(b) Definitions for the terms used in subdivision (a) of Section 10181.3 may include, but shall not be limited to, whether approving the application will result in a rate that is in accordance with generally accepted actuarial principles.

10181.1. (a) No applicant shall increase the rate it charges a policyholder unless it submits an application to the department, and the application is approved by the department.

(b) Every application submitted to the department pursuant to this section shall be signed by the officers of the applicant who exercise the functions of a chief executive and chief financial officer. Each officer shall certify under penalty of perjury that the representations, data, and information provided to the department to support the application are true.

(c) Every application submitted to the department pursuant to this section shall include, in summary form, the following information:

(1) The rate of return that will result if the application is approved.

(2) The average premium increase per affected insured that will result from approval of the application.

(3) The medical loss ratio reserves and surpluses that will result if the application is approved.

(4) A summary of all of the applicant's nonmedical expenses for the most recent fiscal year.

(d) All materials submitted to support an application shall be a public record. The summaries required by the applicant shall be posted on the department's Internet Web site within 10 days of the date of their receipt by the department.

10181.2. A rate increase imposed by a health insurer between April 1, 2000, and January 1, 2004, shall be a rate application for purposes of this article. If it fails to comply with the requirements of subdivision (a) of Section 10181.3, the department shall order a refund in an amount required to ensure compliance with those requirements, together with interest at the prevailing rate from the date the rate increase was imposed.

10181.3. (a) No application, pursuant to Section 10181.1 or 10181.2, shall be approved if its rate is excessive, inadequate, or unfairly discriminatory or if the insurer's benefits are unreasonable in comparison to the rate, or the application otherwise violates this article.

(b) The applicant has the burden to provide the department with evidence and documents establishing the application's compliance with the requirements of subdivision (a).

10181.4. The department shall conduct its review of an application pursuant to subdivision (a) of Section 10181.3 in accordance with regulations determining reasonable rates of return, reserves, surpluses, and nonmedical expense amounts.

10181.5. (a) If the department disapproves the application submitted under Section 10181.1 or orders a refund pursuant to Section 10181.2, the applicant may petition for a hearing pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(b) The applicant has the burden at the hearing of proving by a preponderance of the evidence that the application or the rate charged by the health insurer between April 1, 2000, and January 1, 2004, meets the requirements of subdivision (a) of Section 10181.3 or the failure to approve the application or requiring the payment of a refund pursuant to Section 10181.2 will result in an unconstitutional confiscation. If the applicant prevails in this proof, the department shall order the minimum nonconfiscatory rate or refund.

(c) At least 30 days before the date of a hearing held under this section, the department shall notify the public of the hearing and the procedures for intervening in the hearing pursuant to Section 10181.7 by posting this information on its Internet Web site.

(d) Nothing in this section limits the discretion or authority of the department to provide interim or temporary relief from a potentially confiscatory rate or from a confiscatory rate.

10181.6. A consumer or an intervenor participating pursuant to Section 10181.7 may request that the commissioner hold a hearing to determine whether an existing rate charged by a health insurer satisfies the requirements of subdivision (a) of Section 10181.3. If the request is denied, the commissioner shall provide a written explanation of his or her reasons for the denial.

10181.7. A consumer or a group representing the interests of consumers may petition to intervene in a proceeding under this article and to obtain compensation.

10181.8. A violation of this article is subject to the penalties set forth in Section 1859.1. The commissioner may also suspend or revoke in whole or in part the certificate of authority of a health insurer for a violation of this article.

10181.9. (a) The department may charge health insurers a fee for the actual, reasonable costs of implementing this article.

(b) The fees shall be deposited into the Health Insurer Rate Approval Fund which is hereby created in the State Treasury. Notwithstanding Section 13340 of the Government Code, all moneys in this fund are continuously appropriated to the department for the sole purpose of implementing this article.

10181.10. The department has all necessary and proper powers to implement this article including, but not limited to, the authority to adopt regulations. The department shall adopt regulations to implement this article no later than July 1, 2004.

~~SEC. 6.~~

SEC. 4. The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

~~SEC. 7.~~

SEC. 5. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

O